MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12201

# CERTIFICATE OF DEATH

12202

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Adaline | Bartik | | Sept. 29 1969 | 8:30 p. M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Female | White | Nov. 29, 1884 | 84 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Mc Coole, Md. | 448 Maryland Ave. | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Mc Coole | YES ☒ NO ☐ | 448 Maryland Ave. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Hugh | Mac | Millan | Jenny | | Shockey |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| no | | Mr. John W. Bartik, Mc Coole, Md.-Son |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 4510 | IMMEDIATE CAUSE (a) *Pulmonary embolus* | 6 hrs. |
| | DUE TO, OR AS A CONSEQUENCE OF (b) *Thrombophlebitis , rt. leg* | 6 hrs |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
*Carcinoma of colon with abdominal carcinomatosis*

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 5/31/69 | carcinoma of colon | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5/30/ , 19 69 , to 9/29 , 1969 , that (I) (~~xxx~~) last saw the deceased alive on 29 September 1969 , and that in (my) (~~xxx~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Harry F. Coffman M.D. | M.D. | | | | 30 Sept. 1969 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Harry F. Coffman, M.D. | 537 S. Mineral Street Keyser, W.Va. 26726 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct. 2, 1969 | St. Mary's Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | OCT 2 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

12202

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12203

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: HERMAN | Middle: MORRIS | Lost: Bernstein | 2a. DATE OF DEATH Month: Sep | Day: 7 | Year: 69 | 2b. HOUR: 12:45 A M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: May 1, 1883 | 6. AGE (In years last birthday): 86 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Sylvan Retreat | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Salesman | 12b. KIND OF BUSINESS OR INDUSTRY: Furniture | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland, | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 836 Greene St. | | | |
| 14. FATHER'S NAME First: Morris | Middle: -- | Lost: Bernstein | 15. MOTHER'S MAIDEN NAME First: Molly | Middle: -- | Lost: Mendelsohn | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No, | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-05-6342 | 17. INFORMANT: Mr. Maurice Bernstein | Address: 836 Greene St. Cumb. Md. | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Four minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Chr. A. S. H. D — many years
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis — many years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Senile psychosis. Fx. Rt. Hip. 3/8/69

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this hospital) attended the deceased from Mar 1, 1968, to Sep 7, 1969, that (I) (we) last saw the deceased alive an Sep 7 1969, and that in (my) (aur) opinian death accurred an the dote and haur and fram the causes stated abave, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John A Topper MD | | ☒ | ☐ | ☒ | 9-7-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| John A Topper MD | Memorial Hospital Cumberland, Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 9/10/69 | East View Cem. | Cumberland, | Allegany | Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| H. Wayne George | Cumberland, Md. | SEP 11 1969 | Charles Judge |

VR A15 (4)
45M - 1X69

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

12203

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12204

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MARGARET | ADELGUNDA | BOLT | Sept. 4, 69 | 9 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month Day Year 19 | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | JUNE 1, 1916 | 53 YRS. | | | Sept. 4, 1969 | 9 AM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ECKHART | DOA-Miners Hospital | SALESLADY | STORE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | ECKHART | YES [X] NO [ ] | (ECKHART), MD. R.F.D.2, BOX 51, FROSTBURG |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| THOMAS | P. | FELDMANN | CATHERINE | | SULLIVAN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Address) |
|---|---|---|---|
| NO | N.A. | 217-10-7507 | MR. JOHN FELDMANN, R.F.D.2, BOX 51, FROSTBURG, MD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 4109 | IMMEDIATE CAUSE (a) CORONARY OCCLUSION | SUDDEN |
| | DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY THROMBOSIS | " |
| | DUE TO, OR AS A CONSEQUENCE OF (c) CORONARY SCLEROSIS | --- |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X], and in my opinion death resulted from: Natural causes [X] Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: Sept. 4, 1969

ADDRESS (Street, city, town or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 9/6/69 | ST. MICHAELS CEM. | FROSTBURG MARYLAND |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MARILOU M. SOWERS Marilou M. Sowers | HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG | SEP 9 1969 | Charles Judge |

VR A15ME (5)
10M REV. 1/68

1

**FOR STATE HEALTH DEPT.**

Items 18, 22a, Film C418
11/4/69, cr

12204

# MARYLAND STATE DEPARTMENT OF HEALTH
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12205

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Daphney | Ann | Butts | 9-30-69 19 | 9a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | 28 Mar 1969 | — YRS. | 6 | | | | September 30, 1969 | 10:35 a M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| West Virginia | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Westernport | 224 Woods St. | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Westernport | X | 224 Woods St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Gerald | E. | Butts | Sharon | Ann | Keller |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Gerald Butts | Westernport, Md. 224 Woods St. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Asphyxiation | MINUTES |
| DUE TO, OR AS A CONSEQUENCE OF | | " |
| (b) | Aspiration of stomach contents | |
| DUE TO, OR AS A CONSEQUENCE OF | | |
| (c) | Bronchopneumonia | 24 - 36 hrs |

485 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED September 30, 1969

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 4 Oct 69 | Potomac Mem. Park | Keyser, Mineral W. Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Allen M. Rotruck | Keyser, W. Va. | OCT 6 1969 | Charles Judge |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

FOR STATE HEALTH DEPT.

Items 18, 22a, Film G418 11/4/69 cr

12205

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12206

| 1. DECEASED-NAME (Type or Print) First | Middle | Lost | 2o. DATE KNOWN OF DEATH ESTIMATED | 2b. HOUR |
|---|---|---|---|---|
| Gertrude | Margaret | Butts | XX 9-30-69 19 | 9 a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | IF UNDER 1 YEAR: DAYS | IF UNDER 24 HRS.: HOURS | IF UNDER 24 HRS.: MIN. | 2c. DATE PRONOUNCED DEAD Month, Day, Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | 28 Mar 1969 | — YRS. | 6 | | | | September 30, 1969 | 10:35 am |

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| West Virginia | U.S.A. | NEVER MARRIED X | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Westernport | 224 Woods St. | | |

| 13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Westernport | YES X NO | 224 Woods St. |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Gerald | E. | Butts | Sharon | Ann | Keller |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | | Gerald Butts | Westernport, Md. 224 Woods St. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (o) Asphyxiation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

485.X

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) Aspiration of stomach contents — "

DUE TO, OR AS A CONSEQUENCE OF (c) Bronchopneumonia — 24 - 36 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21o. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy X Inspection X Inquiry X and in my opinion death resulted from: Natural causes X, Accident , Suicide , Homicide , Undetermined manner

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED September 30, 1969

ADDRESS(Street, city, town, county) Cumberland, Maryland

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 4 Oct 69 | Potomac Mem. Park | Keyser, Mineral W. Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Allen M. Fetsch | Keyser, W. Va. | OCT 6 1969 | Charles Judge |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12206

# CERTIFICATE OF DEATH

12207

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Agnes | Middle: Margaret | Last: Canning | |
| 2a. DATE OF DEATH | Month: 9 | Day: 22 | Year: 69 | 2b. HOUR: 420P M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: 3-6-93 | 6. AGE (In years last birthday): 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): Md. | 7b. CITIZEN OF WHAT COUNTRY?: America | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Cumberland Nursing Center | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housework | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 543 Fairview Ave. |
| 14. FATHER'S NAME First: James | Middle | Last: Nolan | 15. MOTHER'S MAIDEN NAME First: Rosemary | Middle / Last: Collins |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-07-0072-D | 17. INFORMANT Address: Florence Grabenstein-Daughter | | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Congestive heart failure | 5 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic heart disease | 20 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | generalized arteriosclerosis & osteoarthritis | 20 yrs |

Conditions, if ony, which gave rise to immediote cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
cerebral arteriosclerosis with senility

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: none | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: none | 20a. AUTOPSY? YES ☐ NO # ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.): none | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State: none | |

22a. I certify that (I) (this hospital) attended the deceased from July 3, 19 69, to Sept. 22, 19 69, that (I) (we) last saw the deceased olive on ### 9-22-69 19___, and that in (my) (our) opinion death occurred on the date ond hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | |
|---|---|---|---|---|
| 22b. SIGNATURE: James P. Hallinan M.D. | DEGREE: ATTENDING PHYS. # ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 9-22-69 | | |
| 22d. PHYSICIAN'S NAME (Type): James P. Hallinan M. D. | 22e. ADDRESS: 140 Bedford St., Cumberland, Md. 21502 | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/25/1969 | 23c. NAME OF CEMETERY OR CREMATORY: St. Michael's Catholic Cem | 23d. LOCATION (City or Town): Frostburg | (County): Alleg (State): Md. |
| 24. FUNERAL DIRECTOR: Charles E. Hafer | ADDRESS: Charles E. Hafer, 230 Balto Ave. Cumberland Md. | 25a. REC'D BY REGISTRAR DATE: SEP 24 1969 | 25b. REGISTRAR'S SIGNATURE: [illegible] | |

VR A15 (A)
45M - 7/69

1

12207

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12208

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: JOSEPHINE Middle: NMI Last: CHANEY | | 2a. DATE OF DEATH Month: 9 Day: 21 Year: 69 | 2b. HOUR: 2:15 M |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 01 15 19 | 6. AGE (In years last birthday): 50 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: BARTON | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER |
| 14. FATHER'S NAME First: LAWRENCE Middle: McKenzie Last: MCKENZIE | | 15. MOTHER'S MAIDEN NAME First: CATHERINE Middle: NOLAN Last: MC KENZIE | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214 07 6985 | 17. INFORMANT Address: HOSPITAL RECORDS -900 SETON DRIVE CUMBERLAND, MD. 21502 | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Bilateral bronchopneumonia - severe | 9-20-69 |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Post operative for thrombosis | 9-18-69 |
| DUE TO, OR AS A CONSEQUENCE OF (c) | right popliteal artery | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Liver disease

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Thrombosis right Popliteal artery | 20a. AUTOPSY? YES [X] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to 9-21-, 1969, that (I) (we) last saw the deceased alive on 9-21- 1969, and that in (my) (our) opinion death occurred on the date and haur and from the causes stated obove, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Carl Paul — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 9-21-69

22d. PHYSICIAN'S NAME (Type): DR. E. PAUL — 22e. ADDRESS: 414 N. MECHANIC ST., CUMBERLAND, MD. 2150

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 24, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. View Cem. | 23d. LOCATION (City or Town): Moscow Mills | (County): Allegany Md. |

24. FUNERAL DIRECTOR: BOAL-S FUNERAL SERVICE — ADDRESS: WESTERNPORT, MD. 21562

25a. REC'D BY REGISTRAR DATE: SEP 25 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 45M - 7/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12208

# CERTIFICATE OF DEATH

12209

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| FREEMAN | GODFREY | COOK | 09 24 69 | 5:40 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 06-16-14 | 55 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | TRUCK DRIVER - EASTERN EXPRESS | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [ ] NO [X] | RT. #1, BOX 512, CUMB., MD. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | C. | COOK | (BOWMAN) EMMA | R. | COOK |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| YES | 214-05-5995 | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronoma, left lung, bronchogenic, with

DUE TO, OR AS A CONSEQUENCE OF (b) lymph node metastases and esophageal

DUE TO, OR AS A CONSEQUENCE OF (c) stenosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from [illegible], 19 50, to 9/24, 19 69, that (I) (we) last saw the deceased alive on 9/23 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| [signature] | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 9/24/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| S.G. WEISMAN, M.D. | 59 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/26/69 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George GEORGE FUNERAL HOME-202 GREENE ST., CUMB., MD. | SEP 29 1969 | [signature] Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12209.

# CERTIFICATE OF DEATH

12210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2o. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| MAURICE | M. | COOK | 09 | 18 | 69 | 5:20AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 6-19-31 | 38 YRS. | | |

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | U. S. A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Glass worker | Glass |

| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | RAWLINGS | YES [ ] NO [X] | RT. 3 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | | COOK | HATTIE | | MONGOLD |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| Yes | 1/49-3/50 | 236-42-0173 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma tongue, extensive & metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.
141.9
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20o. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21o. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 1968, 19____, to Sept 18, 1969, that (I) ~~(we)~~ last saw the deceased alive on Sept 17 1969, and that in (my) ~~(our)~~ opinian death occurred on the date and haur and from the causes stated abave, (I) ~~(we)~~ ~~(did)~~ (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Carlton Brinsfield | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 9-18-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. BRINSFIELD | CUMBERLAND, MD. |

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/20/69 | Dawson Cemetery | Allegany, Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Allen M. Rogers | ROGERS FUNERAL HOME, KEYSER, W. VA. | SEP 25 1969 | Charles Judge |

VR A15 (4) 45M - 1/69

1

12210

# STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

12211

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year |
| WILBUR | C | COOPER | 9 11 69 |

2b. HOUR: 8:00 AM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 7-10-87 | 82 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VIRGINIA | U.S.A. | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 400 GRAND AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| DANIEL | | COOPER | LOUISA | (MARY T. ) | CARLILE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No | 705-05-8563 | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 hour

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio-Vascular Disease — years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) ~~(his hospital)~~ attended the deceased from 9-10-69, 19___, to 9-11-69, 19___, that (I) (we) last saw the deceased alive on 9-10-69, 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| | | [X] | [ ] | [ ] | 9-13-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. G.O. HIMMELWRIGHT | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | Sept. 14, 1969 | Indian Mound Cemetery | Romney, W. Va. | | Hampshire |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | SEP 16 1969 | Charles Judge |

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12211

# CERTIFICATE OF DEATH

12212

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| NETTIE | C. | CRABTREE | 09 | 28 | 69 | 2:00P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | MAR 2-10-01 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. XXXXX | Allegany | 6 Mi. West PAW PAW | YES [X] NO [ ] | RT.#1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | | PLATT | SLIDER , | NANCY | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | | | MEMORIAL HOSPITAL | CUMB. MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 minutes
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost. 4122
(b) Hypertensive arteriosclerotic cardiovascular disease — 20 years
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes mellitus and renal failure.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| — | — | YES [ ] NO [X] | — |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 28 Sept, 19 69, to 28 Sept, 19 69, that (I) (we) last saw the deceased alive on 28 Sept 19 69 and that in (my) (our) opinian death occurred on the date and haur and fram the causes stated abave. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Joseph W. Miller by proxy for W.F. Williams | ATTENDING PHYS. | [X] | MED. DIRECTOR | [ ] STAFF PHYS. [X] | 29 Sept 69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. F. WILLIAMS | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| Burial | Oct.1,1969 | Sulphur Spring Cem. | Near Oldtown, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | OCT 2 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2-1 as soon as possible. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12212

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12213

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: John | Middle: Albert | Last: Crass | 2a. DATE KNOWN OF DEATH ESTIMATED [X]: Month Day Year: Sept. 29, 1969 | 2b. HOUR: 5:15 P M | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: May 12, 1910 | 6. AGE (In years last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year: September 29, 1969 | 2d. HOUR: 5:30a M |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X] | 9. COUNTY OF DEATH: Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Rear B&O Y. M. C. A. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Machinist | 12b. KIND OF BUSINESS OR INDUSTRY: Textile | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 7 Laing Ave. | | | |
| 14. FATHER'S NAME First: George A. Crass | Middle | Last | 15. MOTHER'S MAIDEN NAME First: Lula T. | Middle: Hardman | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give wars or dates of service): War II | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mr. Edward R. Crass | ADDRESS: Cumberland, Md.-Son | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Hemothorax, Crushed Chest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

805X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): (Run over by Locomotive)

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 5:15 P.M. 9-29-69 | Run over by Locomotive |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | Railroad Track, rear | of B&O, YMCA, Cumberland, Allegany, Md. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [XX], Inspection [XX], Inquiry [XX] and in my opinion death resulted from: Natural causes [ ], Accident [XX], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED: September 29, 1969

ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct. 1, 1969 | St. Mary's Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| James F. Scarpelli | Cumberland, Md. | SEP 30 1969 | Charles Judge |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

12213

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12214

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Harry | E. | Creal | 9 | 11 | 69 | 2:30 P. M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | 5/21/1887 | 82 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Ohio | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | Allegany Cumberland, Md. Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland, Maryland | Allegany County Home | Machinist | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES [X] NO [ ] | 313 N. Centre Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Edward | | Creal | Hattie | | Hazman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| YES | WWI | | Allegany County Home Records. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebro-Vascular Accident
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hrs. / Yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Dec. 12, 19 60, to Sept. 11, 19 69 that (I) (we) last saw the deceased alive on Sept. 10, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| George M. Simons | | [X] | [X] | [X] | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| George M. Simons | Memorial Hospital, Cumberland, Maryland |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/13/69 | RoseHill Cemetery | Cumberland Allegany Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Silcox-Merritt Funeral Service, Cumberland, Md 21502 | SEP 15 1969 | Charles Judge |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12214 — 12215

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year |
| JAMES | M. | DENTINGER | 9 12 69 |

2b. HOUR: 6:00 P

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 01 04 23 | 46 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARITAL | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD. | USA | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | Retired RR Disability | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 200 HUMBIRD STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | | DENTINGER | HAZEL | GREEN | DENTINGER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | | SACRED HEART HOSPITAL -900 SETON DRIVE CUMBERLAND, MARYLAND |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

575 X

IMMEDIATE CAUSE (a) Aspiration of Vomitus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Gangrenous perforated Cholecystitis — 3 days

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Severe Generalized Rheumatoid Arthritis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 9-2-69 | Gangrenous Perforated Cholecystitis | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | N/A |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from 8-22, 1969, to 9-10, 1969, that (I) (~~we~~) last saw the deceased alive on 9-10 1969, and that in (~~my~~) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William R Wolverton M D | | ☒ | ☐ | ☐ | 9-15-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. WILLIAM R. WOLVERTON | XX DETROIT DRIVE -CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 15, 1969 | St. Mary's Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCARPELLI FUNERAL HOME -108 VA AVE -CUMB., MD. | SEP 18 1969 | Charles Judge |

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| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

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12215

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12216

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: LAWRENCE Middle: Lost: DONAHUE | 2a. DATE OF DEATH Month Day Year: SEPTEMBER 27, 1969 | 2b. HOUR: PM 11:15 | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 4-29-82 | 6. AGE (In years last birthday): 87 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MD. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER: 303 VIRGINIA AVE., |
| 14. FATHER'S NAME First: LAWRENCE Middle: Lost: DONAHUE | 15. MOTHER'S MAIDEN NAME First: ELLEN Middle: Lost: BEGLEY | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary artery disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

4121

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive C V disease — years

DUE TO, OR AS A CONSEQUENCE OF (c) Uremia — weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that (I) (this hospital) attended the deceased from Jany, 1969, to Sept 27, 1969, that (I) (we) last saw the deceased alive on Sept 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: [signature] DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | | 22c. DATE SIGNED: 9/29/69 |
| 22d. PHYSICIAN'S NAME (Type): SE. BLANE SCHINDLER | 22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 10/1/69 | 23c. NAME OF CEMETERY OR CREMATORY: Philos |
| 23d. LOCATION (City or Town) (County) (State): Westernport-Allegany-Md. | | |
| 24. FUNERAL DIRECTOR: E. S. Boal ADDRESS: Westernport, Md. | 25a. REC'D BY REGISTRAR DATE: OCT 3 1969 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12216

# CERTIFICATE OF DEATH

12217

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ELSIE | Middle: M | Last: DUCKWORTH | 2a. DATE OF DEATH Month: SEPTEMBER Day: 11 Year: 1969 | 2b. HOUR: 6:35 PM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 4-19-96 | 6. AGE (In years last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): PENNA. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNA. | 13b. COUNTY: BEDFORD | 13c. CITY OR TOWN: HYNDMAN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: ROUTE #1 | |
| 14. FATHER'S NAME First: ROBERT | Middle: | Last: WALLIZER | 15. MOTHER'S MAIDEN NAME First: EFFIE | Middle: | Last: KEPPLER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: None | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Artery Disease
DUE TO, OR AS A CONSEQUENCE OF (c): Generalized Arteriosclerosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9-8-, 1969, to 9-11-1969, that (I) ~~(we)~~ last saw the deceased alive on 9-11-1969 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: W. F. Williams DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 9-13-69 | | |
| 22d. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS | 22e. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 14, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: Zoin Memorial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md | |
| 24. FUNERAL DIRECTOR: William G. Kight | ADDRESS: Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 16 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Snode | |

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12217

# CERTIFICATE OF DEATH

12218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| LAURA | E. | EVERLY | 09 02 69 | 12:45 |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 11 24 84 | 84 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | MARRIED X | ALLEGANY CO., MD. Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | HOUSEWIFE | OWN HOME |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | 12 BOONE STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JAMES | | WESTBROOK | (KELL) MARGARET | | WESTBROOK |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | | PATIENT'S HOSPITAL CHART | 900 SETON DRIVE CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4121

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis & hypertensive heart disease — 3 days

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus; Cerebral arteriosclerosis; Peripheral Arteriosclerosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES NO | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospitol) attended the deceased from 8/31, 1969, to 9/2, 1969, thot (I) (we) last saw the deceased alive on 9/2 1969, ond thot in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body ofter deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | | ☐ | ☐ | ☐ | 9/3/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| S.G. WEISMAN, M.D. | 59 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 5, 1969 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCARPELLI FUNERAL HOME, 108 VIRGINIA AVE, CUMBERLAND, MD. 21502 | SEP 8 1969 | Charles Judge |

VR A15 (R)
45M - 1/69

LAURA . A. EVERLY 09 02 69 12:45

FEMALE WHITE 11 24 84 04

X

MARYLAND U.S.A. ALLEGANY CO., MD.

CUMBERLAND SACRED HEART HOSPITAL HOUSEWIFE

MARYLAND ALLEGANY CUMBERLAND X 12 BOONE STREET

JAMES WESTBROOK (KELL) MARGARET WESTBROOK

MD PATIENT'S HOSPITAL CHART 200 SETON DRIVE CUMBERLAND, MD.

S.G. WEISMAN, M.D. 50 GREENE ST., CUMBERLAND, MD. 21502

SCARPELLI FUNERAL HOME, 100 VIRGINIA AVE. CUMBERLAND, MD. 21502

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12218 12219

| 1. DECEASED-NAME (Type or Print) First | Middle | Lost |
|---|---|---|
| Leo | Melvin | Everly |

2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month 9 Day 26 Year 1969 — 2b. HOUR 6:30 PM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS HOURS | IF UNDER 24 HRS MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | Feb. 22, 1911 | 58 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month 9 Day 26 Year 1969 — 2d. HOUR 6:30 PM

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Laborer | Brewing Co. |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 219 Race St. |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| James Everly | Lottie Crawfis |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| yes | War II | | Mrs. Ruth Everly, Cumberland, Md. Wife |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Thrombosis — 〃

DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Sclerosis — ----

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

ADDRESS (Street, city, town, or county) Cumberland, Md.

22b. DATE SIGNED Sept. 26, 1969

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 29, 1969 | Hillcrest Burial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | SEP 30 1969 | Charles Judge |

1

12219

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12220

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| VANCE | B. | FAZENBAKER | 9 | 10 | 69 | 4:45 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 9-9-11 | 58 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | UNEMPLOYED | ****** |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES ☒ NO ☐ | RT.2 BOX 284 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| arthur | | FAZENBAKER | LILLIE | | ENFIELD |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | 220-10-1957 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cause unknown | 4 days. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Radical gastrectomy | 6 wks. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Carcinoma of stomach | 1½ yrs. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

151.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Postop fistula of undetermined origin

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | Ca of stomach | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospitol) attended the deceased from 24 July, 19 69, to 10 Sept, 19 69, that (I) (we) last saw the deceased alive on 10 Sept 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Milton Berger Jr M.D. | | ☒ | ☐ | ☐ | 12 Sept 69. |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. MILTENBERGER | CUMBERLAND, MARYLAND |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-13-69 | Laurel Hill Cem | Barton, Allegany Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Harper Bowers Funeral Home<br>Gary Lynn Beachy | 60 W. Main St.<br>Frostburg, Md. | SEP 19 1969 | |

VR A15 (1)
45M - 1X69

4-1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MS. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12220

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12221

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| George | William | Fisher |

2a. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month Sept. Day 6 Year 1969 — 2b. HOUR 1:15 AM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | March 11, 1888 | 81 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month Sept. Day 6 Year 1969 — 2d. HOUR 1:15 AM

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. Va. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | 912 E. Oldtown Rd. | Retired Carman | Railroad |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 912 E. Oldtown Road |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| William R. Fisher | Mary Dodd |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Mrs. Willa Fisher, Cumberland, Md.-Wife |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — --

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED September 6, 1969

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

ADDRESS (Street, city, town, or county) Cumberland, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-8-1969 | Rose Hill Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | SEP 9 1969 | |

VR A15ME (5) 10M REV. 1/68

1

12221

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12222

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: BABY BOY | Middle: LARRY | Last: ALLEN GARLITZ | 2a. DATE OF DEATH Month: 9 Day: 9 Year: 69 | 2b. HOUR: 10:10 AM | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 9-9-69 | 6. AGE (In years last birthday): — YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. 23 |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): None | 12b. KIND OF BUSINESS OR INDUSTRY: None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 404 YORK PLACE | |
| 14. FATHER'S NAME First: LARRY | Middle: A | Last: GARLITZ | 15. MOTHER'S MAIDEN NAME First: FRANCES | Middle: E | Last: DELAWDER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: None | 17. INFORMANT: MEMORIAL HOSPITAL | Address: CUMBERLAND, MD. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Circulatory Obstruction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b): Incomplete delivery c Cord Compression

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c): Locked heads in Twins

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: Leland B Ransom M.D. | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED: 12 Sept 69 |
| 22d. PHYSICIAN'S NAME (Type): Dr. Leland B. RansomM.D. | | 22e. ADDRESS: 401 Decatur St., Cumberland, Md. | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept.12,1969 | 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. | ADDRESS | 25a. RECD BY REGISTRAR DATE: SEP 15 1969 | 25b. REGISTRAR'S SIGNATURE: [illegible] Judge | |

VR A15 (1) 45M - 1 69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13648

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12223

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Harry | Middle: Edward | Last: Gough, Jr. | | | | | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month: Sept. | Day: 1 | Year: 1969 | 2b. HOUR: 1 a M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Dec. 16, 1940 | 6. AGE (In years last birthday): 28 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | | 2c. DATE PRONOUNCED DEAD: Month: September | Day: 1. | Year: 1969 | 2d. HOUR: 1a M |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): None-Disabled | 12b. KIND OF BUSINESS OR INDUSTRY: None | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: La Vale | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: 22 Roselawn Ave. | | | | | | | |
| 14. FATHER'S NAME: First: Harry E. | Middle: | Last: Gough, Sr. | 15. MOTHER'S MAIDEN NAME: First: Kathleen | Middle: | Last: Jones | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes | (If yes give war or dates of service): 1959-1960 | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: Mrs. Mary Gough, 22 Roselawn Ave. LaVale, Md | | | | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot of Head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO, OR AS A CONSEQUENCE OF
(b): (Self Inflicted)
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955 X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [X], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
22b. DATE SIGNED: September 1, 1969
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 4, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 4 1969 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge | |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

12222 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12224

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DH3 Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Henry | Middle: Sebastian | Last: Grabenstein | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month: 9 Day: 20 Year: 69 | 2b. HOUR: 10:00 AM | | | | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 11-11-90 | 6. AGE (In years last birthday): 78 YRS. | IF UNDER 1 YEAR MONTHS: | DAYS: | IF UNDER 24 HRS. HOURS: | MIN.: | 2c. DATE PRONOUNCED DEAD Month: September Day: 20 Year: 1969 | 2d. HOUR: 10:00 AM |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DOA-Memorial Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired | 12b. KIND OF BUSINESS OR INDUSTRY: Dairy Farmer | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany MD | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Route #2 | | | | | |
| 14. FATHER'S NAME First: John | Middle: | Last: Grabenstein | 15. MOTHER'S MAIDEN NAME First: Unknown | Middle: | Last: | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: Mrs. Mary Llewellyn, Cumberland, Maryland | | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

(b): CORONARY SCLEROSIS — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: September 20, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, M.D.

| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 23, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: SS. Peter + Paul Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md. |
|---|---|---|---|

| 24. FUNERAL DIRECTOR / ADDRESS | 25a. REC'D BY REGISTRAR DATE: SEP 24 1969 | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Louis Stein, Inc. Cumberland, Md. | | |

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12223

# CERTIFICATE OF DEATH

12225

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| PHYLLIS | J. | GREEN | 09 18 69 | 1:50 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 08 17 44 | 25 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | NEVER MARRIED [X] | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | NONE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | BARTON | YES [ ] NO [ ] | RT.#1, BARTON, MD. 21521 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| HARRY | | GREEN | (BITTINGER) DORA | | GREEN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CARCINOMA OF COLON? Carcinomatous change | 2 weeks |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Secondary to? ULCERATIVE COLITIS | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

153.8
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
THYROTOXICOSIS — treated 10 yrs ago & HYPOTHYROIDISM as result; LUPUS ERYTHEMATOSIS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 1959, to 18 Sept, 1969, that (I) (we) lost saw the deceased alive on 17 Sept 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| S.G. Weisman | | [X] | [ ] | [ ] | 18 Sep 69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| S.G. WEISMAN, M.D. | 59 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/21/1969 | Laurel Hill Cemetery | Moscow, Md. All. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| EICHHORN FUNERAL HOME, 8 E. MAIN ST., LONACONING, MD. 21539 | SEP 22 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
45M - 9/69

1

12224

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12226

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| AGNES | V. | HAMMERSMITH | 09 16 69 | 5:25PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 3-4-87 | 82 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | NONE | NONE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 1816 BEDFORD STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| PATRICK | | PENDERGAST | BRIDGET | | MURPHY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 214-07-6675 | HOSPITAL RECORD, 900 SETON DR., CITY 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-DAYS
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Cardiovascular Disease — 10 YRS
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 67, to 9-16, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 9-16 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| L. M. Glick | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 9-17-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. L. M. GLICK | 912 SETON DRIVE -CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/19/69 | St. Peter & Paul Cem. | Cumberland Allegany Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| KIGHT'S FUNERAL HOME, DECATUR ST., CITY 21502 | SEP 22 1969 | Charles Junge |

VR A15 14
45M - 7/69

12225

Item6 Film G17 10/6/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12227

1. DECEASED-NAME (Type or print): First (DORY) Middle THEODORE Last HANN
2a. DATE OF DEATH: Month 09 Day 29 Year 69
2b. HOUR: M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: March 22, 1903
6. AGE (In years last birthday): 66 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): Penna.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Garman
12b. KIND OF BUSINESS OR INDUSTRY: Railroad
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET AND NUMBER: 120 W. OLDTOWN RD.
14. FATHER'S NAME: First Thomas Middle Lost Hann
15. MOTHER'S MAIDEN NAME: First Minnie Middle Last Hosselrode
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.
17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | pulmonary embolism. | hours. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | congestive heartfailure | months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | coronary artery disease | years. |

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [X] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes.
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town Caunty State

22a. **I certify** that (I) (this haspital) attended the deceased from 9/27, 19 69, to 9/29, 19 69, that (I) (we) last saw the deceased alive an 9/27 19 69, and that in (my) (our) opinian deoth accurred an the date ond hour and from the causes stated abave, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: P B Halmos DEGREE ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]
22c. DATE SIGNED: 9/30/69
22d. PHYSICIAN'S NAME (Type): DR. P. B. HALMOS
22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL: Burial
23b. DATE: Oct. 2, 1969
23c. NAME OF CEMETERY OR CREMATORY: Davis Memor. Cemetery
23d. LOCATION (City or Town) (Caunty) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: OCT 2 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (2)
45M - 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12226

# CERTIFICATE OF DEATH

12228

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| FRANCES | M | HARRIS | 9 | 13 | 69 | 8:48 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 9-8-87 | 82-82 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.VA. | U.S.A. | WIDOWED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | 115 FEDERAL ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| SAMUEL | | LYNCH | JANE | (FARRELL) | MONROE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| no | | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Melanosarcomatosis, general
DUE TO, OR AS A CONSEQUENCE OF (b) Primary site RVE
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1729
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 yr

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | NO | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospital) attended the deceased from [illegible], 1960, to 3 Sept, 1969, that (I) (we) last saw the deceased alive on 9-12-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | | X | ☐ | ☐ | 9/13/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. S. G. WEISMAN | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 16, 1969 | Greenmount Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | SEP 16 1969 | [signature] Registrar, Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physicion and completely filled in, the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremotion, or removal, and in ony event, within 72 hours after death.

VR A15 M
45M - 1-66

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12227

12229

FOR STATE HEALTH DEPT.

| 1. DECEASED-NAME (Type or Print) | First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|---|
| | JOHN | JAMES | HENAGMAN | ☒ | SEPT. | 5, | 1969 | 12:10 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | JULY 22, 1885 | 84 YRS. | | | | | SEPTEMBER 5, 1969 | 12:10 PM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL-DOA | STATIONARY ENGINEER | SCHOOL |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 2 GRAND AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| FRANCIS | | HENAGHAN | MARY | | MEARS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 217-09-0012 | BARNARD HENAGHAN, ECKHART, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — --

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described obave, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED SEPTEMBER 5, 1969

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | SEPT. 8, 1969 | ST. MICHAEL'S CEMETERY | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | SEP 10 1969 | Charles Judge |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

12228

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| HITE | MARY | C. | 9 | 30 | 69 | 3:15 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | Apr. 5, 1902 04-05-02 | 67 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 17 MARY STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JAMES | | GEPHART | ANNIE | HODEL | GEPHART |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 214 07 2171-D | SACRED HEART HOSPITAL | 900 SETON DRIVE CUMBERLAND, MARYLAND 21502 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | ACUTE MYOCARDIAL INFARCTION | 2 DAYS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | HYPERTENSIVE HEART DISEASE | 5 YRS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | DIABETES MELLITUS | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

OBESITY GENERALIZED ARTERIOSCLEROSIS

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| NONE | | | NONE |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| NONE | | NONE |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | NONE | | | | |

22a. I certify that (I) (this hospital) attended the deceased from SEPT 28, 69 to SEPT. 30, 69, that (I) (we) last saw the deceased alive on SEPT. 30, 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. # | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Donald J. Hallinan M.D. | | | | | 10-1-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. J.P. HALLINAN | 140 BEDFORD STREET -CUMBERLAND, MARYLAND |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Oct. 3, 1969 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SCARPELLI FUNERAL HOME -108 VA. AVENUE CUMBERLAND, MARYLAND | OCT 3 1969 | Charles Jones |

VR A15 (3) 45M · 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12229 12231

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: RICHARD Middle: S. Last: HOTCHKISS | 2a. DATE OF DEATH: 9 Month 3 Day 69 Year | 2b. HOUR: 6:35 A.M. | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 1-13-84 | 6. AGE (In years last birthday): 85 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (State or foreign country): W. Va | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CUMBERLAND NURSING & CONV. CENTER | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Coal Miner | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET AND NUMBER: Rt. #1 Box 321 | | | |
| 14. FATHER'S NAME First: JAMES Middle: — Last: HOTCHKISS | 15. MOTHER'S MAIDEN NAME First: AGNES Middle: — Last: SCOTT | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 216-05-5704 | 17. INFORMANT Address: Mrs. Jane Eliz Secrist Severn, Md | |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CHRONIC RENAL FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 582X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Atherosclerotic heart disease.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 8-29, 19 69, to 9-3, 19 69, that (I) (we) last saw the deceased alive on 9/2 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: P B Halmos MD DEGREE | ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 9/3/69 | |
| 22d. PHYSICIAN'S NAME (Type): P.B. HALMOS | 22e. ADDRESS: 302 SCHLEY ST. (CUMBERLAND) | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/6/69 | 23c. NAME OF CEMETERY OR CREMATORY: Memorial Park | 23d. LOCATION (City or Town): Frostburg | (County): A. (State): Md |
| 24. FUNERAL DIRECTOR: George Eichhorn | ADDRESS: Lonaconing, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 5 1969 | 25b. REGISTRAR'S SIGNATURE: [illegible] | |

VR A15 (4) 45M 68

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12230 — 12232

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: BABY | Middle: GIRL | Last: HOTT | 2a. DATE OF DEATH Month: 9 Day: 5 Year: 69 — 2b. HOUR: 8:10 AM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 9-5-69 | 6. AGE (In years last birthday): — YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS 5 / MIN 13 |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 319 CAROLINE ST. |
| 14. FATHER'S NAME First: DALE | Middle | Last: HOTT | 15. MOTHER'S MAIDEN NAME First: CAROLYN | Middle: L. | Last: COOPER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: None | 17. INFORMANT: MEMORIAL HOSPITAL | Address: CUMBERLAND, MD. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b): Prematurity (25 weeks gest.)

DUE TO, OR AS A CONSEQUENCE OF (c):

7762

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert Brodell M.D. DEGREE — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (Type): DR. ROBERT BRODELL XXXXXXXXXXXXXXXX — 22e. ADDRESS: CUMBERLAND, MD.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9-6-1969 | Hillcrest Burial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | SEP 9 1969 | Charles Judge |

VR A15 (4)
45M - 1/69

Item#22a, FilmG417 9/29/69 km

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12231

# CERTIFICATE OF DEATH

12233

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ROBERT | R | INSKEEP | SEPTEMBER 16 1969 | PM 10:50 |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 4-28-00 | 69 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD | ALLEGANY | BARTON | YES [X] NO [ ] | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| OTHE | | INSKEEP | SARAH | | RUSSELL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| no | | 214-05-8138 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinoma lung, left lower lobe. | 3 months ? |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Wilt gen. metabolasis | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospital) attended the deceased from 15 July, 1969, to ~~17~~ 16 Sept, 1969, that (I) ~~(we)~~ last saw the deceased alive on ~~17~~ Sept. 16 1969, and that in (my) ~~(our)~~ opinian deoth accurred on the date and haur and from the causes stated abave, (I) ~~(we)~~ (did) ~~(did not)~~ view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| W. Alfred Van Ormer M.D | | [X] | [ ] | [ ] | 18 Sept 69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. A. VAN ORMER | 122 S. CENTRE ST., CUMBERLAND, MD |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/20/69 | Philos | Westernport-Alle. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| L. Beal | Westernport, Md 21562 | SEP 22 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
45M - 1/69

4 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12232

# CERTIFICATE OF DEATH

12234

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ESTELLA | C. | JEFFRIES | SEPT. 1, 1969 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | FEB. 14, 1888 | 81 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | MINERS HOSPITAL | HOUSE WORK | OWN HOME |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | MT. SAVAGE | YES [X] NO [ ] | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | | HAMMERS | BRDIGET | | O'BRIEN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | NONE | MRS. MARCUS HAUGHTON, CUMBERLAND, MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic myocardial failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Chronic arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 momths

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I ar Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at wark / Nat while at wark | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street ar R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from Feb.28, 19 69, to Spet 1 19 69, that (I) (we) last saw the deceased alive an Aug.29 19 69, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| A. Paige Strong, MD | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | | Sept.1, 1969 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| A. Paige Strong | 167 E.Main St.-Frostburg, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | SEPT. 4, 1969 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | SEP 5 1969 | Helen L. Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital ar attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remave carbon papers. Page 4 should be filed with the State Dept. af Health priar ta burial, crematian, ar removal, and in any event, within 72 hours after death.

VR A15 (1)
45M - 1X68

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12233

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12235

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| THOMAS | BENJAMIN | JONES | SEPT. 4th 69 | 8 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | 10-30-88 | 80 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Virginia | U. S. A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Sylvan Retreat | Fireman Ret. | City of Cumberland, |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES [X] NO [ ] | 106 Karns Avenue |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| William | -- | Jones | Laura | -- | Weaver |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO, | | 219-54-2146 | Mr. Carl E. Jones | 205 Wilmont Ave. Cumb. Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | acute renal insufficiency | approx 2 wks |
| DUE TO, OR AS A CONSEQUENCE OF (b) | due ASHD. | many years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Pan-Arteritis Sclerosis | many years. |

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus. Senile Psychosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from April 15 19 67, to Sept. 4, 19 69, that (I) (we) last saw the deceased alive on Sept. 4 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John A Topper MD | | [X] | [ ] | [ ] | 9-6-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| John A. Topper MD | Memorial Hospital Cumberland, Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 9/6/69 | Hillcrest Burial Park, | Cumberland, | Allegany | Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| H. Wayne George | Cumberland, Maryland | SEP 9 1969 | Charles Judge |

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12234

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12236

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: VIRGIE | Middle: (ANDERSON) | Last: JONES | | | | | 2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year: 9-27-69 | | | 2b. HOUR: 6:45 P.M. |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: DEC. 3, 1907 | 6. AGE (In years last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | | 2c. DATE PRONOUNCED DEAD Month Day Year: September 27, 1969 | | | 2d. HOUR: 6:45 P.M. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY | | | | | | | | Md. |
| 10. CITY OR TOWN OF DEATH: FROSTBURG | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Miner's Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE WORK | 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: FROSTBURG | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 156 BOWERY STREET | | | | | | | |
| 14. FATHER'S NAME: First REED | Middle | Last ANDERSON | 15. MOTHER'S MAIDEN NAME: First VIOLA | Middle | Last FAZENBAKER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 216-38-1834 | 17. INFORMANT: MRS. CAROLYN BULLERJOHN | ADDRESS: BUDDLAKES, N. J. | | | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: September 27, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | SEPT. 30 '69 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | OCT 1 1969 | Charles Judge |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12235

# CERTIFICATE OF DEATH

12237

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ELVA | L | KLINE | SEPTEMBER 23, 1969 | 8:25 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 1-6-91 | 78 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | HWFE. | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. VA. | MINERAL | RIDGELEY | YES [X] NO [ ] | 66 Potomac St. FRANTZ APARTMENTS #5 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| PERRY | | MC COOLE | GERTRUDE | | LARGENT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT (Name, Address) |
|---|---|---|
| No. | None | Clarence A. Kline Ridgeley, W. Va. MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma ovary, with generalized

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1½ years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 27 Aug, 1969, to 23 Sept, 1969, that (I) ~~(we)~~ last saw the deceased alive on 22 Sept 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| W. Alfred Van Ormer | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 25 Sept. 69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. ALFRED VANORMER DR. A. J. MIRKIN | 115 S. CENTRE ST., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/26/69 | Hillcrest Burial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George Cumberland, Md. | SEP 29 1969 | J. Charles Judge |

VR A15 (4) 45M - 11-68

1

12236

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12238

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH | 2b. HOUR |
|---|---|---|---|---|
| SAMUEL | KOPLOVITZ | | 09 Month 15 Doy 69 Year | 5:40P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 3-3-98 | 71 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| CUMBERLAND | U. S. A. | MARRIED X | ALLEGANEY CO. Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | PHYSICIAN | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. VA. | MINERAL | KEYSER | YES X NO | 94 W. MAIN ST. |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| HEINMAN | KOPLOVITZ | | IDA | unknown | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| Yes WW1 and11 | 234 62 3540 | MEMORIAL HOSPITAL, CUMB. MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Lipoсarcoma (retroperitoneal) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-3 mos.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if ony, which gove rise to immediote cause (a), stoting the underlying couse lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| Aug 19. 1969 | Tumor Abdomen | YES NO X | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Aug 7, 1969, to Sept 15, 1969, that (I) (we) last saw the deceased olive on Sept 15 1969, and that in (my) (our) opinion death occurred on the date and hour and from the couses stated obave, (I) (we) (did) (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] M.D. | | X | ☐ | ☐ | Sept 16. 1969 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. DONALD GROVE | 122 S. Centre St. Cumberland Md |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 18 Sept 69 | Chisuk Emuna | Harrisburg, Dauphin Pa. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Allen M. Potucke | Keyser, W.Va. | SEP 19 1969 | [signature] |

VR A15 (4)
45M - 1/69

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Item5 Film G417 10/3/69 kk

12237

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12239

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 5 may be retained for your files. the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) | First | Middle | Last | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| | Lorenza | Calvin | Lambert | 9-27-69 | | | 2:55a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | April 18, 1882 1969 | 87 YRS. | | | | | September | 27, | 1969 | 2:55a M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.Va. | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Farmer | Farm |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Westernport | YES [X] NO [ ] | 253 Main St. Ext. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Benjiman | S | Lambert | Gracie | "Lambert" | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| no | | 220-10-1580 | Pearl Tinsley | Westernport, Md. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cardiac Decompensation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease — ----

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Fracture of Right Hip

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [X] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11:00 P.M. 9-22-1969 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | Fell down steps at home |

| 21d. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | Home | 253 Main Street, | Westernport, | Alleg. | Maryland |

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [XX] Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED: September 27, 1969

ADDRESS (Street, city or town): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/29/69 | Philos | Westernport-Allegany-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| E. J. Beal | Westernport, Md. | SEP 30 1969 | Charles Jones |

VR A15ME (5) 10M · 1/69

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medicol Examiner's Office along with form MM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12238

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12240

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH / ESTIMATED — Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Eugene | Clair | Landis | X Sept. 18, 1969 | 3p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Male | White | March 7, 1881 | 88 YRS. | | | September 18, 1969 | 3p M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Ohio | U.S.A. | MARRIED X | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | 114 Park Street | Retired City Tax Collector | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md | Allegany | Cumberland | YES X NO | 114 Park Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| William | H | Landis | Mary | | Eichman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 219-14-5077 | Mrs. Elizabeth Landis | 114 Park Street Cumberland, Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES NO X |

| 21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (At home, form, street, factary, affice building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy ☐, Inspectian X, Inquiry X, and in my apinian death resulted from: Natural causes X, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED: September 18, 1969

ADDRESS(Street, city, town, county): Cumberland, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/ 22/69 | S.S. Peter & Paul Cemetery | Cumberland Allegany Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Silcox-Merritt Funeral Service. Cumberland, Md 21502 | SEP 22 1969 | Charles Gordon |

VR A15ME (5) 10M REV. 1/68

1

12239

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

12241

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ESTELLA | V. | LARGENT | 9 8 69 | 8:05 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 5-16-96 | 73 YRS. | 3 / 22 | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | HOUSEWIFE-RETIRED | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. VA. | Morgan | PAW PAW | YES ☒ NO ☐ | BOX 373 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| CHARLES | | SPEROW | ELLA | | THOMAS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease — ?

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 ar Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street ar R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from 9-1-69, 19 69 to 9-8-69, 1969, that (I) ~~(we)~~ last saw the deceased alive an 9-8-69 19 69 and that in (my) ~~(our)~~ opinion death accurred an the date and haur and from the causes stated abave, (I) ~~(we)~~ ~~(did)~~ (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Wm. F. Williams | | ☒ | ☐ | ☐ | 9-9-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. F. WILLIAMS | 122 S. CENTRE ST., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City ar Town) (County) (State) |
|---|---|---|---|
| BURIAL | Sept. 11, 1969 | Bethel Cem. | PAW PAW, MORGAN W.VA. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| [illegible] Johnson | JOHNSON FUNERAL HOME, BERKELEY SPRINGS, W.VA. | SEP 16 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12240

# CERTIFICATE OF DEATH

12242

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| FRANK | | MAGRUDER | 9 11 69 | 9:58A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 9-9-90 | 79 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | Allegany | BARTON | | Box 311 Barton, Md. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| GEORGE | | MAGRUDER | HARRIETT | M. | Michael |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| no | 216 07 6753 | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebral vascular accident | 2 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic C.V.D. for about ? | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 9-9-, 19 69, to 9-11-, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 9-10- 19 69 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Wm. F. Williams | | [X] | [ ] | [ ] | 9-11-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. F. WILLIAMS | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/11/69 | Mt View Cem. | Moscow Mills Allegany Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| E. J. Boal | Westernport, Md. 21562 | SEP 16 1969 | J. Charley Judge |

VR A15 M
45M - 1-68

1

12241

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12243

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Edmund | George | McCoy | at 9:00 P.M. September 7, 1969 | P.M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | 4/1/1886 | 83 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U. States of A. | WIDOWED [X] | Allegany County Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Allegany County Infirmary | Retired:Glass Wrkr.-Ser.Station | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES [X] NO [ ] | Rt.#1, Box 201 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| William | | Stevens | Mary | | McCoy |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | |
|---|---|---|---|
| | 186-30-1759 | P.O.Box 599, Cumberland, Md. 21502 | Allegany County Infirmary records. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia

DUE TO, OR AS A CONSEQUENCE OF

(b) Adeno-carcinoma prostate

DUE TO, OR AS A CONSEQUENCE OF

(c) Gen Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 185 X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospitol) attended the deceosed from Dec. 27, 19 67, to Sept. 7, 19 69, thot (I) (we) last sow the deceosed alive on Sept. 7 19 69 and that in (my) (aur) opinion death occurred on the dote ond hour ond from the causes stoted obave, (I) (we) (did) (did not) view the body ofter deoth.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| George M Symons | ATTENDING PHYS. [X] MED. DIRECTOR [X] STAFF PHYS. [X] | Sept. 8, 1969 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | Memorial Hospital, Cumberland, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept 9, 1969 | Washington Cemetery | Washington Washington Penna |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Charles E Hafer | Charles E Hafer, 230 Baltimore Ave. Cumberland Md | SEP 10 1969 | Charles Judge |

VR A15 (4)
45M - 1/69

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12242

# CERTIFICATE OF DEATH

12244

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: MARY | Middle: M. | Last: MC GREEVY | 2a. DATE OF DEATH Month: 09 Day: 26 Year: 69 | 2b. HOUR: 5:30 PM | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 04-27-05 | 6. AGE (In years last birthday): 64 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY COUNTY, Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE-Sales Ad. | 12b. KIND OF BUSINESS OR INDUSTRY: Newspaper | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 11 N. JOHNSON STREET | | |
| 14. FATHER'S NAME First: JOHN | Middle: A. | Last: MALLOY | 15. MOTHER'S MAIDEN NAME First: (O'ROURKE) MARGARET | Middle: | Last: MALLOY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-05-6445 | 17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | Address: MD. 21502 | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARCINOMATOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

1621

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CA OF LUNG — 1YR

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 4, 19 69, to 9-25, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 9-25 19 69, and that in (my) ~~(our)~~ opinian death accurred an the date and haur and fram the causes stated abave, (I) ~~(we)~~ (did) (~~did not~~) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: L M Glick | MD DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED: 9-26-69 |
| 22d. PHYSICIAN'S NAME (Type): L. M. GLICK | 22e. ADDRESS: 912 SETON DR CUMBERLAND | | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept. 29, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: SCARPELLI FUNERAL HOME | ADDRESS: 108 VA. AVE., CUMB., MD | 25a. REC'D BY REGISTRAR DATE: SEP 30 1969 | 25b. REGISTRAR'S SIGNATURE: J Charles Judge | |

VR A15 (1)
45M - 1-68

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12243

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12245

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2o. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| Stewart | Nicholas | McKenty | ☒ / ☐ | Sept. | 15, | 1969 | 12:35 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD: Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | May 13, 1913 | 56 YRS. | | | | | September | 15, | 1969 | 12:35 PM |

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Sheet Metal Work | Construction |

| 13o. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES ☒ NO ☐ | 729 Gephart Drive |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| George | B. | McKenty | Jane | | Nelson |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| No | | 214-05-4169 | Mary N. Robertson, 729 Gephart Drive |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | 30 Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY THROMBOSIS | " |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21o. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED SEPTEMBER 15, 1969

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | Sept. 18, 1969 | Oak Hill Cemetery | Lonaconing | Allegany | Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25o. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| H. Wayne George | Cumberland, Maryland | SEP 22 1969 | J. Charles Judge |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12244

# CERTIFICATE OF DEATH

12246

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| THERESA | B. | MEYERS | 09 27 69 | 6:20 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 10-09-89 | 79 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | NONE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | LONACONING | YES ☒ NO ☐ | 38 ST. MARY'S TERRACE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | | MEYERS | (KNAUP) ELIZABETH | | MEYERS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | 212-32-8356 | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | MD. 21502 |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | PULMONARY EMBOLUS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | THROMBO PHLEBITIS LEFT LONG SAPHENOUS | 10 DAYS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4510

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to 9-27, 1969, that (I) ~~(we)~~ last saw the deceased alive on 9-26 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and haur and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| L. M. Glick MD | | ☒ | ☐ | ☐ | 9-27-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L. M. GLICK | 912 SETON DR CUMBERLAND |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| 9/29/1969 | Burial | St. Marys Cemetery | Lonaconing, Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| EICHHORN FUNERAL HOME, | 8 E. MAIN, LONACONING MD | SEP 29 1969 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in panel in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12245

**MARYLAND STATE DEPARTMENT OF HEALTH**
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12247

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| BERNARD | THOMAS | MICHAELS | X | Sept. | 17 | 1969 | 1p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN. | 2c. DATE PRONOUNCED DEAD: Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | SEPT. 9, 1914 | 55 YRS. | | | | | September | 17, | 1969 | 4 p M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| ECKHART, MD. | U.S.A. | WIDOWED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ECKHART | FROSTBURG R.F.D.1, BOX 624, | CURING ROOM | KELLY TIRE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES / NO X | BOX 624 (ECKHART) R.F.D. 1, FROSTBURG |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOSEPH | | MICHAELS | ANNIE | | MARTIN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| NO | N.A. | 214-07-2365 | MR. EUGENE J. MICHAELS, | BOX 624 FROSTBURG, MD. R.F.D.1, |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Asphyxiation | 20-30 Min. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carbon Monoxide Poisoning | 20-30 Min. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

9521

Conditions, if any, which gove rise to immediote couse (a). stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21a. EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy XX Inspection X, Inquiry X, and in my opinian death resulted from: Natural causes ☐, Accident ☐, Suicide X Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED September 17, 1969

ADDRESS (Street, city, town or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | SEPT. 20, 1969 | STT MICHAEL'S CEM. | FROSTBURG, ALLEGANY, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG Marilou M. Sowers | SEP 22 1969 | Charles Judge |

VR A15ME (5) 10M REV. 1/68

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12246

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12248

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Muriel | Joy | Middleton | 9/23 | | 1969 | 8 pM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Female | White | 10/17/1894 | 74 YRS. | | | | | September | 23, | 1969 | 9 pM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Near Oldtown | Rt.#4, Brice Hollow Road | None | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland Oldtown | YES ☐ NO ☒ | Rt.#4, Brice Hollow Road |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Donald | | Middleton | Laura | | Twigg |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Donald Middleton, Route 4, Brice Hollow | Cumberland, Md |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION

DUE TO, OR AS A CONSEQUENCE OF

(b) CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) SUDDEN (b) -- (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED September 23, 1969

ADDRESS(Street, city, town, c... CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/26/1969 | Mt. Tabor Methodist Cem | Allegany Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Charles E. Hafer | Charles E. Hafer, 230 Balto Ave. Cumberland Md. | SEP 26 1969 | Charles Judge |

VR A15ME (5) 10M REV. 1/68

4109

00 01 1 2 2

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12247

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12249

| 1. DECEASED-NAME (Type or Print) First | Middle | Lost | 2a. DATE KNOWN OF DEATH / ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| Sadie | | Miller | X / | 9-30-69 | | 19 | 12:45 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | Mar. 19, 1875 | 94 YRS. | | | | | September 30, 1969 | 12:45 AM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Virginia | U.S.A. | WIDOWED X | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Sacred Heart Hospital | H.W. | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Westernport | YES / NO X | Rt. 1 |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Charles Whittington | | | Martha | Shue | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| no | | | Gilbert Barton-Westernport, Md. 21562 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pulmonary Embolism — Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Fracture of Right Hip — 2 days

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 887X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| 9-30-69 | Open reduction of right hip | YES / NO X |

| 21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING / CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 1:00 P.M. 9-30-69 | Fell in back yard |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK X | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | Home | R#1 | Westernport, | Allegany, | Maryladd |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection X, Inquiry XX, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED: September 30, 1969

ADDRESS (Street, city, town, county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10/3/69 | Philos | Westernport-Allegany-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| C. L. Beal | Westernport, Md. | OCT 2 1969 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12248

# CERTIFICATE OF DEATH

12250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: WILLIAM | Middle: James | Last: MOORE | 2a. DATE OF DEATH: SEPT Month 21 Day 1969 Year | 2b. HOUR: 12 58 M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 11-18-85 | 6. AGE (In years last birthday): 83 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country): VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SHH, SETON DR., CUMB. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED-COAL MINER&CARPENTER | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: GARRETT ✓ | 13c. CITY OR TOWN: KITZMILLER | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: W. Main Street | | |
| 14. FATHER'S NAME First: JOHN | Middle: Bolden | Last: MOORE | 15. MOTHER'S MAIDEN NAME First: ELIZABETH | Middle: [illegible] | Last: TAYLOR | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 213-01-6622 | 17. INFORMANT: HOSPITAL RECORD | Address | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
CHRONIC LUNG DISEASE

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from 9-21, 1969, to 9-21, 1969, that (I) (we) last saw the deceased alive on 9-21 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ ~~(did not)~~ view the body after death.

22b. SIGNATURE: M Matthew L Kaufman DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 9-21-69.

22d. PHYSICIAN'S NAME (Type): DR. M. KAUFMAN — 22e. ADDRESS: CUMBERLAND, MD. 21502

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE: 9/24/69 | 23c. NAME OF CEMETERY OR CREMATORY: Short Run Cemetery | 23d. LOCATION (City or Town) (County) (State): R.D. Kitzmiller, Garrett Co. Md. | |
| 24. FUNERAL DIRECTOR: Amy Mildred Shaffer | ADDRESS: Blaine, W.Va. P.O. Kitzmiller, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 25 1969 | 25b. REGISTRAR'S SIGNATURE: Julian L. Judge | |

VR AIS (4)
45M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12249

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12251

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN X OF DEATH ESTIMATED ☐ Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| AUGUSTUS | PHILIP | MOWERY | Sept. | 8, | 1969 | 4 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | Sept. 4, 1893 | 76 YRS. | | | | | Sept. | 8, | 1969 | 4 PM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED X DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Penna. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | DOA Memorial Hospital | Machinist Helper | Celanese Corp |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Oldtown | YES ☐ NO X | RFD #1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Joseph | | Mowery | Rosa | | Redinger |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| Yes | WW I | 214-05-9003 | Loyd Mowery, RFD #1, Oldtown, Md. (Son) |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gove rise to immediate couse (a), stoting the underlying couse lost.
(b) CORONARY SCLEROSIS — **
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO X |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took chorge of the remoins described obove, held on Autopsy ☐, Inspection X, Inquiry X, and in my opinion deoth resulted from: Noturol couses X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
22b. DATE SIGNED: September 8, 1969
ADDRESS(Street, city, town, or co): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/11/69 | Davis Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Charles E. Hafer, 230 Balto.Ave., Cumberland, Md. | SEP 15 1969 | Charles Judge |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

1

12250

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12252

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ERNEST | W. | MURPHY | SEPTEMBER 17, 1969 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | MAY 13, 1889 | 80 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | LABORER | KELLY TIRE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [X] NO [ ] | 155 BOWERY STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | | MURPHY | (CROWE) HENRIETTA | | MURPHY |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| | | 214-07-0653 | MRS. ERNEST W. MURPHY, 155 BOWERY ST., FROSTBURG, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinoma of colon & regional metastases | 1 year |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2113

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Ventricular fibrillation during operation

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 29 Aug 69 | 18a | YES [ ] NO [X] | [redacted] |

| 21a. ACCIDENT? WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10 Aug, 1969, to 17 Sept, 1969, that (I) (we) last saw the deceased alive on 17 Sept 19 69, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| M Miltenberger M.D. | | [X] | [ ] | [ ] | 19 Sept 69. |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| F.W. MILTENBERGER, M.D. | 122 S. CENTRE ST., CUMBERLAND, MD. 2150 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 9/19/69 | CHURCH CEM. NEW GERMANY REFORMED | GARRETT, MARYLAND |

| 24. FUNERAL DIRECTOR | ADDRESS | 25d. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MARLIN M. SOWERS Mailed F.M. Sowers HAFER-SOWERS FUNERAL HOME-FROSTBURG, MD. | | SEP 22 1969 | Jessie Judge |

VR A1S (R)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12251 12253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in ony event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: LA VERNIA | Middle: K. | Last: NIXON | 2a. DATE OF DEATH Month: SEPTEMBER Day: 8, Year: 1969 | 2b. HOUR: 0:45 P.M. |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: ~~XXXXXX~~ 2-11-20 | 1920 | 6. AGE (In years last birthday): 49 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED X NEVER MARRIED WIDOWED DIVORCED | | 9. COUNTY OF DEATH: ALLEGANY | Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES X NO | 13e. STREET AND NUMBER: 878 MARYLAND AVE., | |
| 14. FATHER'S NAME First: ROBERT | Middle: | Last: BAKER | 15. MOTHER'S MAIDEN NAME First: MARY | Middle: | Last: HOUSER |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMB. MD. | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO, OR AS A CONSEQUENCE OF

(b) Squamous cell carcinoma of penis — 10 years

DUE TO, OR AS A CONSEQUENCE OF

(c)

180X

Conditians, if ony, which gave rise to immediate cause (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 1968 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Left leg lymphedema | 20a. AUTOPSY? YES NO X | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from Sept, 1968, to 6 Sept, 1969, that (I) (we) last saw the deceased alive on 6 Sept 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: Fred W. Miltenberger | M.D. DEGREE | ATTENDING PHYS. X | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED: 8 Sept 69. |
| 22d. PHYSICIAN'S NAME (Type): DR. F. MILTENBERGER | | 22e. ADDRESS: CUMBERLAND, MD. | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept.9,1969 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. | ADDRESS | 25a. REC'D BY REGISTRAR DATE: SEP 9 1969 | 25b. REGISTRAR'S SIGNATURE | |

VR AIS 14 45M - 1-68

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12252

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12254

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: HOWARD | Middle: LEROY | Last: NORTHCRAFT | 2a. DATE OF DEATH Month: 9 Day: 8 Year: 69 | 2b. HOUR: 9:50 AM |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 9-25-13 | 6. AGE (In years last birthday): 55 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U S A | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): PRESSMAN | 12b. KIND OF BUSINESS OR INDUSTRY: NEWS PAPER | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 810 SHADES LANE | |
| 14. FATHER'S NAME First: ELLIS | Middle | Last: NORTHCRAFT | 15. MOTHER'S MAIDEN NAME First: VANCE | Middle | Last: CLARK |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-05-6643 | 17. INFORMANT: PTS. HOSP CHART | Address: SACRED HEART HOSP. 900 SETON DRIVE CUMBERLAND, MD. 21502 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDITIS
4123
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
ANTERIOR MYOCARDIAL INFARCTION OLD (1959)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [X] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify that (I) (this haspital) attended the deceased from _____, 19 62, to 9-8, 19 69, that (I) (we) last saw the deceased alive an 9-8 19 69, and that in (my) (our) apinion death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did not) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Lm Glick | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 9-8-69 | |
| 22d. PHYSICIAN'S NAME (Type): L.M.GLICK, M.D. | 22e. ADDRESS: 912 SETON DRIVE, CUMB., MD. 21502 | | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/10/69 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland |
| 24. FUNERAL DIRECTOR: Merritt-SILCOX FUNERAL HOME | ADDRESS: 404 DECATUR ST. CUMB., MD. 21502 | 25a. REC'D BY REGISTRAR DATE: SEP 11 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge |

VR A15 (4)
45M - 1/69

L.M.GLICK, M.D.

215-05-6042

21502

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ... Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

12253 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12255

| 1. DECEASED-NAME (Type or Print) First | Middle | Lost |
|---|---|---|
| John | Lear | Oliver |

2o. DATE KNOWN OF DEATH ESTIMATED ☒ Month Sept Day 13 Year 1969 — 2b. HOUR ? M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS HOURS | IF UNDER 24 HRS MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | Jan. 7, 1915 | 54 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month Sept Day 25 Year 1969 — 2d. HOUR 4PM

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U S A | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| La Vale | 19 Parkside Blvd. | Auto Salesman | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | La Vale | YES ☒ NO ☐ | 19 Parkside Blvd |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| John | A. | Oliver | Sophia | | Lear |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW 2 | 219-03-9148 | John Tracy Oliver | 808 Ashland Ave. Cumberland Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis — ------

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county)

22b. DATE SIGNED September 25, 1969 Cumberland, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 29, 1969 | Hillcrest Burial Park | Near Cumberland Alleg Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Charles E. Hafer Hafer Funeral Service 230 Balto Ave. Cumberland Md | SEP 29 1969 | Charles Judge |

VR A15ME (S)
10M REV. 1/68

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12254 — 12256

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| CHRISTINE | | O'NEILL | Sept. 14, 1969 | 8:15 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| Female | White | April 30, 1906 | 63 YRS. | | | September 14, 1969 | 8:15 PM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| (USA) Maryland. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Sacred Heart Hospital—DOA | Nurse | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES ☒ NO ☐ | 519 Bedford St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| H.C. | | Lewis | Carrie | | Hartung |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| NO | — | | Mrs. Carrie Lewis, 519 Bedford St. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | — |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED September 14, 1969

ADDRESS (Street, city, town) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/18/69 | SS. Peter & Paul Cem | Cumberland Md. (allegany) |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Louis Stein Inc. Louis Stein Inc, Cumberland Md. 117 Frederick St | SEP 18 1969 | Charles Judge |

VR A15ME (5) 10M REV. 1/68

1

12255

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12257

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| ELMER | J. | REINHARD | 09 05 69 | 4:55 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 10-21-86 | 82 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| OHIO | U.S.A. | WIDOWED [X] | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 508 WASHINGTON STREET |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| JOHN | G. | REINHARD | ( FRAY ) MARY | | REINHARD |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes, give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| YES WWI | 220-44-3650 | SACRED HEART, SETON DR., CUMB., MD. 21502 | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 433.9 | IMMEDIATE CAUSE (a) Massive cerebral infarction | 2 days |
| and | DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral atherosclerosis - general atherosclerosis | 5 years |
| | DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema due to Pneumonia & chronic bronchitis | 18 days |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 9/3/69 | Emphysema - Rt | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |
|---|---|---|
| | | |

22a. **I certify** that (I) (this haspital) attended the deceased from 1960, to 9/5, 1969, that (I) (we) last saw the deceased alive an 9/4 1969, and thot in (my) (aur) opinion death accurred an the date ond hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|
| [signature] | | [X] / [ ] / [ ] | 9/5/69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| S.G. WEISMAN, M.D. | 59 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/8/69 | St Joseph Cem. | Cordova Talbot Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Lans Stein Inc. Cumb. Md | SEP 8 1969 | Charles Judge |

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12256

# CERTIFICATE OF DEATH

12258

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: KIRK | Middle: C | Last: RICHARDSON | 2a. DATE OF DEATH | Month: SEPTEMBER | Day: 22 | Year: 1969 | 2b. HOUR: 11:10 PM |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 10-16-00 | 6. AGE (In years last birthday): 68 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country): CUMB. MD. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, MD. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MERCHANT | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 469 WILLIAMS ST, | | | | |
| 14. FATHER'S NAME First: JOHN | Middle: W | Last: RICHARDSON | 15. MOTHER'S MAIDEN NAME First: SARAH | Middle: | Last: WILLIAMS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214 32 2942A | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mon
DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma of Vocal Cords — 2 yrs
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1610

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from 9-18, 1969, to 9-22, 1969, that (I) (we) last saw the deceased alive on 9-22 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type): BRADDOCK MEDICAL GROUP-BLUE | 22e. ADDRESS: 912 SETON DRIVE, CUMBERLAND, MD. | | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 9/25/69 | 23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK | 23d. LOCATION (City or Town) (County) (State): CUMBERLAND, MD. | |
| 24. FUNERAL DIRECTOR: BYRON KIGHT | ADDRESS: CUMBERLAND, MD. | 25a. REC'D BY REGISTRAR DATE: SEP 29 1969 | 25b. REGISTRAR'S SIGNATURE | |

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12257

# CERTIFICATE OF DEATH

12259

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: JESSIE | Middle: DOLORES | Last: RICKENBACKER | 2a. DATE OF DEATH Month: SEPT Day: 27 Year: 1969 |
| 2b. HOUR: 3:45 A M | | | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 1-18-89 | 6. AGE (In years last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CUMBERLAND NURSING HOME | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): REG. NURSE | 12b. KIND OF BUSINESS OR INDUSTRY: Hospital, |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ |
| 13e. STREET AND NUMBER: SHADES LANE | | | |
| 14. FATHER'S NAME First: DR. | Middle: H. L. | Last: HENRY | 15. MOTHER'S MAIDEN NAME First: M. | Middle: LOUISE | Last: Voight |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 232-26-2914 | 17. INFORMANT: Mrs. Mildred G. House | Address: Rt. # 3 Rawlings, Md. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of cervix, stage four — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs.

DUE TO, OR AS A CONSEQUENCE OF (b):

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

180X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that (I) (this hospital) attended the deceased from Aug. 12, 19 69, to Sept. 26, 19 69, that (I) (~~XX~~) last saw the deceased alive on Sept. 26, 19 69, and that in (my) (~~XX~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Magno P Roque, M.D. DEGREE | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 9/27/69 | |
| 22d. PHYSICIAN'S NAME (Type): MAGNO P. ROQUE, M.D. | 22e. ADDRESS: 924 SETON DRIVE, CUMBERLAND | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/29/69 | 23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery | 23d. LOCATION (City or Town): Cumberland, | (County): Allegany | (State): Md. |
| 24. FUNERAL DIRECTOR: H. Wayne George | ADDRESS: 202 Greene St. Cumberland, Md. | 25a. RECEIVED BY REGISTRAR DATE: OCT 1 1969 | 25b. REGISTRAR'S SIGNATURE: Probate Judge | |

VR A15 (1)
45M - 11-68

1

**FOR STATE HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12258

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12260

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| VIOLA | E. | RITCHIE | Sept. 6, 1969 | 1p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | JULY 6, 1892 | 77 YRS. | | | | | September 6, 1969 | 1p M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | DOA-Miners Hospital | DOMESTIC | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | | 96 FROST VILLAGE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JAMES | | RITCHIE | SARAH | | FISHER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| | 220-30-8736A | MRS. PHYLLIS DeHAVEN, LUTHERVILLE, MD. 210 RIDGELEY RD., |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | --- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |
|---|---|---|
| | | |

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy [ ], Inspectian [X], Inquiry [X], and in my apinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED September 6, 1969

ADDRESS(Street, city, town, or county)

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| BURIAL | SEPT. 6, 1969 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | SEP 10 1969 | Charles Judge |

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

99 01 1

2

2

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12259

# CERTIFICATE OF DEATH

12261

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Ruth | Middle: Elinor | Last: Robertson | 2a. DATE OF DEATH: Month Sept. Day 13 Year 69 | 2b. HOUR: M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: Feb. 20, 1906 | 6. AGE (In years last birthday): 63 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): Garrett | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany | | Md. |
| 10. CITY OR TOWN OF DEATH: Frostburg | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Miners Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): H.wife | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Barton | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: Rt. 36 | |
| 14. FATHER'S NAME First: Charles W. | Middle: | Last: Pysell | 15. MOTHER'S MAIDEN NAME First: Dora | Middle: M | Last: Rodeheaver |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: James G. Robertson | Address: Barton, Md. 21562 | | |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Diabetes Mellitus - Coma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): NONE —

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: ✓ | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: ✓ | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? ✓ |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 ✓ | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) ✓ | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) ✓ | 21f. LOCATION Street or R.F.D. No. ✓ | City or Town | County | State |

22a. **I certify** that (I) (this hospitol) ottended the deceased from _____, 1965, to 9-13, 1969, thot (I) (we) lost saw the deceased olive on 9-13 1969, and thot in (my) (our) opinion death occurred on the date and hour and from the couses stoted above, (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: Martin M. Rothstein | DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED: 9-15-69 |
| 22d. PHYSICIAN'S NAME (Type): MARTIN M. ROTHSTEIN M.D. | 22e. ADDRESS: 48 BROADWAY - FROSTBURG - MD. 21532 | | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/16/69 | 23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill | 23d. LOCATION (City or Town): Moscow Mills | (County): Allegany | (State): Md. |
| 24. FUNERAL DIRECTOR: E. L. Bond | ADDRESS: Westernport, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 22 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | | |

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12260

# CERTIFICATE OF DEATH

12262

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2o. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| JAMES | E. | ROBINSON | 9 17 69 | 11:05A |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 08 31 52 | 17 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U. S. A. | NEVER MARRIED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of wark done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | SACRED HEART HOSPITAL | STUDENT AT HOME | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | LA VALE | YES [X] NO [ ] | 113 SANTA FE ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | | ROBINSON | (HAY) ROMAINE | | ROBINSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | NONE | PATIENT'S HOSPITAL CHART | 900 SETON DRIVE CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIAC ARREST

3304

Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) MUSCULAR DYSTROPHY

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from —, 1963, ta 9-17, 1969, that (I) (~~we~~) last saw the deceased alive an 9-17 1969, and that in (my) (~~our~~) opinion death accurred an the date and haur and fram the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|
| L. M. Glick | ATTENDING PHYS. [ ] MED. DIRECTOR [X] STAFF PHYS. [ ] | 9-17-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. L. M. GLICK | 912 SETON DRIVE, CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (Stote) |
|---|---|---|---|
| Burial | 9/20/1969 | Restlawn Memorial Gardens | Near Cumberland, Alleg. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| HAFER FUNERAL HOME | 60 XX MAIN ST XXXXXXXXXXXXXXXX FROSTBURG; CUMB., MARYLAND 21502 | SEP 22 1969 | Charles Jones |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Sheet 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
45M - 1-69

PATIENT'S HOSPITAL CHART

NO.

WILLIAM ROBINSON (HAY) ROANLINE

MARYLAND ALLEGANY LA VALE X 113 SANTA FE ST.

CUMBERLAND, MD. SACRED HEART HOSPITAL STUDENT AT HOME

MARYLAND U. S. A. ALLEGANY

MALE WHITE 08 31 52 17

JAMES E. ROBINSON 9 17 69 11:05A

DR. L. M. CLICK 312 SETON DRIVE, CUMBERLAND, MD. 21502

HAFER FUNERAL HOME - CUMBERLAND, MD. 21502

4 4 1

12261

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12263

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (2) 45M - 7 69

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | PAIGE | Middle M. | Last SENCINDIVER |
| 2a. DATE OF DEATH Month 09 Day 18 Year 69 | | | 2b. HOUR 4:05A M |
| 3. SEX | MALE | | |
| 4. RACE | WHITE | | |
| 5. DATE OF BIRTH | 5-20-00 | | |
| 6. AGE (In years last birthday) | 69 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country) | W. VA. | | |
| 7b. CITIZEN OF WHAT COUNTRY? | U. S. A. | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | |
| 9. COUNTY OF DEATH | ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | MEMORIAL HOSPITAL | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Retired Conductor | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | Railroad | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | MD. | | |
| 13b. COUNTY | ALLEGANY | | |
| 13c. CITY OR TOWN | CUMBERLAND | | |
| 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | | | |
| 13e. STREET AND NUMBER | 107 FIFTH ST. | | |
| 14. FATHER'S NAME First | CHARLES | Middle | Last SENCINDIVER |
| 15. MOTHER'S MAIDEN NAME First | ELLA | Middle R. | Last VOORHES |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | Yes | (If yes, give war or dates of service) War I | |
| 16b. SOCIAL SECURITY NO. | 705-09-3633 | | |
| 17. INFORMANT Address | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Embolism to left femoral artery, — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease — years

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from June, 19 65, to 9-18, 19 69, that (I) (we) last saw the deceased alive on 9-17 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | B M Bohrmann M.D. | DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED 9-18-69 |
| 22d. PHYSICIAN'S NAME (Type) | DR. WEISMAN B M Bohrmann M.D. | 22e. ADDRESS | CUMBERLAND, MARYLAND |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | Sept. 20, 1969 | Restlawn Mem. Gardens | La Vale, Allegany, | Md. |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| James F. Scarpelli, | Cumberland, Md. | SEP 22 1969 | Charles Judge | |

1

12262

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12264

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the informant or director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| PEARL | | SHUEY | SEPT. 19 1969 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | JULY 6, 1889 | 80 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| OHIO | U.S.A. | WIDOWED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | MINERS HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES / NO | 75 ARMSTRONG STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | S. | BUSH | ALICE | | WHITE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| | 214-32-3124 | MRS. RALPH LAYMAN, FROSTBURG, MD. 21532 | 75 ARMSTRONG ST. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Heart Failure (Left) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CVD — 20 yrs?

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

NONE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| ✓ | ✓ | YES / NO X | ✓ |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | ✓ | ✓ |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | ✓ | | ✓ | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 8-2, 19 69, to 9-19, 19 69, that (I) (we) last saw the deceased alive on 9-18 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Martin Rothstein | | X | ☐ | ☐ | 9-19-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| MARTIN ROTHSTEIN, M. D. | 48 BROADWAY, FROSTBURG, MD. 21532 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | SEPT. 22, 1969 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | SEP 23 1969 | Charles Judge |

VR A15 (R)
45M - 1/68

1

12263

Item6 FilmG416 9/8/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12265

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| MARY | FLORENCE | SKELLEY | SEPT. | 3 | 69 | 4:00 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 4-27-83 | 86 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 824 SHAWNEE AVE. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| MICHAEL | | SKELLEY | EMOLINE | V. | FARLOW |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 220-44-5477 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis, remont, severe — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 26 aug 69

4122

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) A. or A. S Cardiovasc. disease with remont congestive heart failure — 5 years

DUE TO, OR AS A CONSEQUENCE OF (c) Hyp. arteriosclerosis — ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospital) attended the deceased from 1 Sept., 19 69, to 3 Sept., 19 69, thot (I) ~~(we)~~ last saw the deceased olive on 2 Sept 69 19___, and that in (my) ~~(our)~~ opinion deoth occurred on the date ond hour ond from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| W. A. Van Ormer, M.D | | ☐ | ☐ | ☐ | 3 Sept. 69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. VAN ORMER | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | SEPT. 5, 1969 | ROSE HILL CEMETERY | CUMBERLAND, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| BYRON KIGHT | CUMBERLAND, MD. | SEP 5 1969 | Charles Judge |

VR A15 MD 45M - 1/68

1

**FOR STATE HEALTH DEPT.**

12264

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12266

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ____. ____ may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Paul | Middle: Vincent | Last: Skelley | 2a. DATE KNOWN ☒ OF DEATH ESTIMATED ☐ Month: Sept. | Day: 27, | Year: 1969 | 2b. HOUR: 1:45 P M | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Sept. 26, 1951 | 6. AGE (In years last birthday): 18 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month: September Day: 27, Year: 1969 | 2d. HOUR: 11:45p M | | |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Deliveryman | 12b. KIND OF BUSINESS OR INDUSTRY: Drug Store | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cresaptown, | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: McKenzie Drive, | | | | | |
| 14. FATHER'S NAME First: James W. | Middle | Last: Skelley | 15. MOTHER'S MAIDEN NAME First: Iona L. | Middle | Last: Carver | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 215-58-6422 | 17. INFORMANT ADDRESS: Mr. James W. Skelley, Rt. # 5 Cumberland, Md. | | | | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Skull Fracture — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8190

DUE TO, OR AS A CONSEQUENCE OF (b): (Auto Accident)

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 10:45 P.M. 9-27-69 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): Driver in one car accident |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.): Rt.9, W.Va. | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State: Near Maryland-West Virginia Line, Mineral, W.Va. |
|---|---|---|

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: Sept. 28, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 10/1/69 | Restlawn Memorial Gardens | Cumberland, Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George 202 Greene St. Cumberland, Md. | OCT 3 1969 | J. Charles Judge |

VR A15ME (3)
10M - 1/69

12265

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

12267

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: MARION | Middle: D. | Last: SLOAN | 2a. DATE OF DEATH: Month SEPTEMBER, Day 1, Year 1969 | 2b. HOUR: 4:00 P M |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 12-3*-1880 | 6. AGE (In years last birthday): 88 YRS. | IE UNDER 1 YEAR: MONTHS / DAYS | IE UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U. S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 778 MAC DONALD TERRACE | |
| 14. FATHER'S NAME: First LEVI, Middle T., Last DEWITT | 15. MOTHER'S MAIDEN NAME: First ROSEMOND, Middle, Last PERCY | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 219-44-0339 | 17. INFORMANT: MEMORIAL HOSPITAL, Address: CUMBERLAND, MD. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebral infarction | 9 days |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) | Cerebral arteriosclerosis 433.9 | 5 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | arteriosclerosis | 10 years |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from ____, 19 68, to 9/1, 19 69, that (I) (we) last saw the deceased alive on 9/ , 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] MD DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 9/2/69

22d. PHYSICIAN'S NAME (Type): S.G. WEISMAN — 22e. ADDRESS: CUMBERLAND, MD.

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE: 9/ 3/1969 | 23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park | 23d. LOCATION (City or Town): Frostburg | (County): Alleg | (State): Md. |
| 24. FUNERAL DIRECTOR: Charles E. Hafer | ADDRESS: Charles E. Hafer, 230 Balto Ave. Cumberland, Md. | 25a. REC'D BY REGISTRAR: SEP 5 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | | |

VR A15 (4) 45M - 1-69

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12266

# CERTIFICATE OF DEATH

12268

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ROSA | Middle: C. | Last: SMEARMAN | 2a. DATE OF DEATH Month: 9 | Day: 8 | Year: 69 | 2b. HOUR: 4:48 P.M. |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 10-19-98 | 6. AGE (In years last birthday): 70 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | | |
| 7a. BIRTHPLACE (State or foreign country): ADDISON, PA. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, MD. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE-RETIRED | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: MT. SAVAGE | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: Rt. 1 | | | |
| 14. FATHER'S NAME First: JOSEPH | Middle | Last: JEFFREYS | 15. MOTHER'S MAIDEN NAME First: MATILDA | Middle | Last: NEIL | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-34-1229 | 17. INFORMANT: MEMORIAL HOSPITAL, | Address: CUMBERLAND, MD. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Leukemia, Lymphocytic, Chronic
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10 Aug, 1969, to 7/8, 1969, that (I) (we) last saw the deceased alive on 8 Sept 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 9/9/69
22d. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN
22e. ADDRESS: 59 GREENE ST., CUMBERLAND, MD.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 9/11/69 | 23c. NAME OF CEMETERY OR CREMATORY: St.JohnsLuth.Ch.Cem. | 23d. LOCATION (City or Town) (County) (State): Accident, Garrett, Md. | |
| 24. FUNERAL DIRECTOR: Kirk Pearson | ADDRESS: Grantsville, Md. | 25a. REC'D BY REGISTRAR DATE: SEP 15 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12267

# CERTIFICATE OF DEATH

12269

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the informant, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Bertha | | Stakem | 9 | 18 | 69 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | White | 9/17/1889 | 80 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.Va | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frostburg | Miners Hospital | House work | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md | Allegany | Lonaconing | YES ☒ NO ☐ | Front Street |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Jerry | | O.Neil | Unknown | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| | | John Stakem | Westernport, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 day
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis — year
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from [illegible] 19[illegible] to 9-18, 1969, that (I) (we) last saw the deceased alive on 9-17 1969 and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did not) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | MD | ☒ | ☐ | ☐ | 9-18-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L.R. MILES, JR | LONACONING MD |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/20/69 | St. Peter & Paul Cemetery | Cumberland A. Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| George Eichhorn | Lonaconing, Md. | SEP 22 1969 | J. Charles Judge |

VR A15 (4) 30M REV. 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12268

# CERTIFICATE OF DEATH

12270

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Andrew | | Steele | Sep, 26th. 1969 | 7:30 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | 1/5/1911 | 58 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD. | USA. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Lonaconing | Washington ST. | Wesvaco Paper Co. | Luke, MD. |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | Allegany | Lonaconing | YES [X] NO [ ] | Washington St. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Andrew | | Steele | Elizabeth | | Todd |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | | 216-07-4030 | Dorthea Steele, Lonaconing, Md. (WIFE) |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) AORTIC INSUFFICIENCY.

DUE TO, OR AS A CONSEQUENCE OF (b) RHEUMATIC HEART DISEASE

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

3950

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic OBSTRUCTIVE LUNG DISEASE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from MAY, 19 69, to SEPT, 19 69, ~~that~~ (I) ~~(we)~~ ~~last~~ saw the deceased alive an 9-25-69, and that in (my) ~~(our)~~ opinion death occurred at the date and haur and fram the causes stated abave, (I) ~~(we)~~ (did) (~~did not~~) view the bady after death.

| 22b. SIGNATURE DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|
| M. Matthew L Kaufman MD | | [X] | [ ] | 9-26-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. Matthew L. Kaufman | Cumberland, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/28/1969 | Oak Hill Cemetery | Lonaconing, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| GEORGE EICHHORN Lonaconing, Md. | SEP 29 1969 | Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12269 12271

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physicion and completely filled in by the funeral director, page 3 should be detached for use os the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to buriol, cremation, or removal, and in ony event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: ADA | Middle: P | Last: TASCHENBERGER | 2a. DATE OF DEATH Month: SEPTEMBER Day: 23 Year: 1969 | 2b. HOUR: 6:47 PM | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 12-7-03 | 6. AGE (In years last birthday): 65 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MD. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HWFE. | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 100 E. FIRST ST., | | |
| 14. FATHER'S NAME First: SYLVESTER | Middle: | Last: STOCKMAN | 15. MOTHER'S MAIDEN NAME First: NANCY | Middle: | Last: KELLY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Pulmonary Edema due to heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: hours

DUE TO, OR AS A CONSEQUENCE OF

(b) Gastrointestinal Hemmorrhage — days

DUE TO, OR AS A CONSEQUENCE OF

(c) Cirrhosis of the Liver — years

571.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Brain Syndrome--Cardiac Arrhythmia

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I certify that (I) (this hospital) attended the deceased from 1955, 19__, to 9-23-69 19__, thot (I) (~~we~~) last saw the deceased alive an 9-23-69 19__, and that in (my) (~~our~~) opinion death occurred on the date and haur and from the couses stated above, (I) (~~we~~) (did) (did not) view the body after deoth.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | 22c. DATE SIGNED: 9-24-69 |
| 22d. PHYSICIAN'S NAME (Type): DR. G. OVERTON HIMMELWRIGHT | 22e. ADDRESS: 133 VIRGINIA AVE., CUMBERLAND, MD. | | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: Sept.26,1969 | 23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. | ADDRESS | 25a. REC'D BY REGISTRAR DATE: SEP 30 1969 | 25b. REGISTRAR'S SIGNATURE: Charles Judge | |

VR A15 (4) 45M - 1-69

1

FOR STATE HEALTH DEPT.

12270

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12272

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First / Middle / Last | Frederick (Calvin) Vanetta | | | 2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year | Sept. 2, 1969 |
| | | | | 2b. HOUR | 12:30a M |
| 3. SEX | Male | 4. RACE | White | 5. DATE OF BIRTH | Jan. 18, 1950 |
| 6. AGE (In years last birthday) | 19 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 2c. DATE PRONOUNCED DEAD Month Day Year | September 2, 1969 | | | 2d. HOUR | 12:30a M |
| 7a. BIRTHPLACE (State or foreign country) | Maryland | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | |
| 9. COUNTY OF DEATH | Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH | Paw Paw, W.Va. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Memorial Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Laborer |
| 12b. KIND OF BUSINESS OR INDUSTRY | Construction | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Md. | 13b. COUNTY | Allegany | 13c. CITY OR TOWN | Route 2 |
| 13d. INSIDE CITY LIMITS? | YES ☐ NO ☒ | 13e. STREET AND NUMBER | Williams Road | | |
| 14. FATHER'S NAME First / Middle / Last | John Vanetta | | | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Thelma Burgess |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | no | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | |
| 17. INFORMANT ADDRESS | Mrs. Julie Vanetta, Cumberland, Md.-Wife | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ruptured Lungs — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Fractured Ribs — " 

DUE TO, OR AS A CONSEQUENCE OF

(c) (Motorcycle accident)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 819.2

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☒ NO ☐ |
| | | |

| | | | | |
|---|---|---|---|---|
| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR | 11:30 P.M. Sept. 1 19 69 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | Motorcycle Accident |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | Street W.Va. | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | Rt. 9, 3 Miles South Paw Paw, Morgan, W.Va. |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: September 2, 1969

ADDRESS (Street, city, town): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE | Sept. 4, 1969 | 23c. NAME OF CEMETERY OR CREMATORY: Mt. Herman Cemetery |
| 23d. LOCATION (City or Town) (County) (State) | Cumberland, Allegany, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | James F. Scarpelli, Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE | SEP 1 1969 | 25b. REGISTRAR'S SIGNATURE: J. Charles Judge |

VR A15ME (5)
10M - 1/69

Items5,6,12&16 FilmG417
10/6/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12271

# CERTIFICATE OF DEATH

12273

| 1. DECEASED-NAME (Type or print) | First | Middle | Last |
|---|---|---|---|
| | DONALD | P. | WHITWORTH |

2a. DATE OF DEATH: SEPTEMBER 15, 1969 — 2b. HOUR: 10:10 PM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 4-28-93 1891 | 78 YRS. | | |

7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U. S. A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street and number): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): PHYSICIAN Dentist
12b. KIND OF BUSINESS OR INDUSTRY: D.D.S.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 204 BEL AIR DRIVE Rt.5

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| RICHARD | H. | WHITWORTH | MARGARET | PRICHARD | |

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 212-38-6572
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Terminal Cerebral Thrombosis, recurrent — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 days
2509
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): A.S. or H. Cardiovascular Disease — 5 years
DUE TO, OR AS A CONSEQUENCE OF (c): Diabetes mellitus — 5 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Empyema L:B with Cholecystostomy 26 aug. 69

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 26 aug 69 | Empyema L. B. | YES [ ] NO [X] | |

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. **I certify** that (I) (this hospital) attended the deceased from 25 aug., 1969, to 15 Sept., 1969, that (I) ~~(we)~~ last saw the deceased alive on 15 Sept 1969, and that in (my) ~~(our)~~ opinian death occurred on the date ond haur and from the causes stated obave, (I) ~~(we)~~ (did) (~~did not~~) view the body ofter death.

22b. SIGNATURE: W. alfred Van Ormer M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 16 Sept. 69
22d. PHYSICIAN'S NAME (Type): DR. W. A. VANORMER
22e. ADDRESS: CUMBERLAND, MD.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept 18, 1969 | Pt Lisa | Westernport Allegany Md. |

24. FUNERAL DIRECTOR ADDRESS: W. Harold Friedlock-Box 4-Piedmont, W. Va.
25a. REC'D BY REGISTRAR DATE: SEP 22 1969
25b. REGISTRAR'S SIGNATURE: Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4
45M - 1/69

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, ar removal, and in any event within 72 hours after death.

12272

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12274

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First | Middle | Last | | | | | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] | Month | Day | Year | 2b. HOUR |
| | Alice | Pearl | Wilson | | | | | | 9/21/69 | 19 | 7:30 AM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. | 2c. DATE PRONOUNCED DEAD | Month | Day | Year | 2d. HOUR |
| Female | White | May 26, 1885 | 84 YRS. | | | | | | September | 21, | 1969 | 9 AM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Flintstone | Route #2 | None | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Flintstone | YES [X] NO [ ] | Route #2 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Eli | | Wilson | Charlotte | Virginia | Growden |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | | Blaine C. Robinette, Rt.#2, Flintstone, Md. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

(b) Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED Sept. 21, 1969

ADDRESS (Street, city, town) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 9/24/69 | Hillcrest Burial Park | Cumberland, Allegany, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Charles E. Hafer, 230 Balto. Ave., Cumberland, Md. | SEP 24 1969 | Charles Judge |

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12273

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12275

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health priar ta burial, crematian, ar removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month Doy Yeor | 2b. HOUR |
|---|---|---|---|---|
| BLANCHE | L. | WISE | 09 12 69 | 11:25A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In yeors lost birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | JUNE 5, 1894 | ~~75~~ YRS. | | |

| 7a. BIRTHPLACE (Stote or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PA. | UNITED STATES | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY COUNTY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | Teacher | |

| 13a. USUAL RESIDENCE (Where deceosed lived. If institution: Residence before odmission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| PA. | A | HYNDMAN | YES [X] NO [ ] | HYNDMAN, PA. |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Solomon J. | Leydig | | Sarah Ellen | (Sides) | Leydig |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | | 179-32-8342 | Paul A. Wise | Hyndman, Pa. 15545 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Gonendyid Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypertension

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | Carcinoma, colon | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from June, 1969, to Sept 12, 1969, that (I) (we) last saw the deceased alive an Sept 12, 1969, and thot in (my) (~~our~~) opinian death accurred on the date and hour and from the causes stoted abave, (I) (~~we~~) (~~did~~) (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Carter Brinsfield MD | | [X] | [ ] | [ ] | 9-12-69 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. BRINSFIELD | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | Sept. 15, 1969 | Hyndman Cemetery | Hyndman, Bedford, Pa. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Harvey H. Zeigler, Hyndman, Pa. 15545 | SEP 15 1969 | Charles Judge |

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